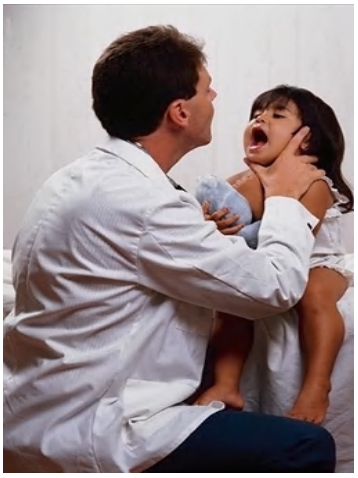
GOAL 3: IMPROVE ACCESS TO HEALTH SERVICES AND ENSURE THE INTEGRITY OF THE NATION'S HEALTH ENTITLEMENT AND SAFETY NET PROGRAMS.

Without insurance, access to health services is severely compromised. With its partners HHS broadens access to services and maximizes the number of low-income or special-needs populations served. HHS also prevents waste, fraud, and abuse of its entitlement and safety net programs, particularly Medicare and Medicaid because of their size and their impact on the total health care system.

Goal (HCFA): Decrease the number of uninsured children by working with states to implement SCHIP and increase enrollment of eligible children in Medicaid.
FY 1999 Target: Establish target and baselines.
FY 1999 Actual: Met.
Trend: FY 1997: 22.7 million in Medicaid; none in SCHIP



Healthy children mean a healthy future and lower health cost.

❖ We are helping to bring about an increase in the percentage of the Nation's children who have health insurance coverage.

Nearly 11 million children in the United States—one in seven—are uninsured because their families cannot afford private insurance and therefore are at significantly increased risk for preventable health problems.

In 1999 HHS continued to work diligently with its partners to develop and implement plans to extend health care coverage to millions of uninsured children. On September 8, 1999, HHS announced that the ***State Children's Health Insurance Program*** (SCHIP), which was passed in the Balanced Budget Act of 1997 and amendments, had been approved in all 56 states and territories in the country. Under the program, Congress and the Administration agreed to set aside $24 billion over five years to help expand health insurance to children whose families earn too much to qualify for traditional Medicaid, yet not enough to afford private health insurance. States are improving their processes to achieve these enrollment levels.

HCFA met its target of developing a FY 2000 objective for decreasing the number of uninsured children by enrolling eligible children in Medicaid and SCHIP. The target is to enroll 1 million more children each year than the prior year.

In FY 1999, SCHIP enabled the states to serve many more women and children because community Health Centers are responding aggressively to the opportunities offered through SCHIP. HRSA and its Health Center grantees recognize that ongoing and intensified outreach and educational efforts will be necessary to assure that all the children who are eligible under SCHIP are enrolled.

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❖ We increased the availability of primary health care services.

There is mounting evidence that access to a usual and regular source of care can reduce and even eliminate health status disparities among subsets of the population. The high quality primary health care received in HRSA's Health Centers has been shown to reduce hospitalizations and emergency room use, reduce annual Medicaid costs, and helps prevent more expensive chronic disease and disability for these populations.

Community Health Centers and the National Health Service Corps (NHSC) combined provides primary health care services to approximately 11.5 million low income, underserved patients. This represents one-fourth of approximately 44 million persons (according to 1998 data) in more than 4,000 communities across the nation who lack access to a primary care provider. For health centers, the patients include 3.52 million uninsured persons, of whom more than 1.2 million are children. This is a 59 percent increase since 1990. To help meet patient needs, 60 percent of the NHSC 2,526 physicians, nurses, dentists, and other primary care providers work in underserved communities throughout the country, in addition to the 40 percent who work in health centers. In FY 1999 they served 4 million of the total patients served.

In FY 1999, 52 new and expanded community health center were funded. The awards increased access to primary and preventive health care for approximately 200,000 underserved people.

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To assure a health professions workforce that meets the health care needs of the American people, HRSA's ***Health Professions Programs*** operate more than 40 grant and student assistance activities focused on improving the diversity and distribution of the nation's health care practitioners. Thirty-three percent of family practice residents and 40 percent of nurse trainees, nurse practitioners, and midwives from HRSA-funded programs practice in medically underserved communities. In FY 1999 HRSA created a federal-state NHSC loan repayment partnership with 35 states to obtain the services of health professionals by repaying their educational loans using matching funds.

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Goal: (HRSA) Increase utilization of health care for underserved populations.
FY 1999 Target: Increase to 8.9 million the number of uninsured and underserved persons served by health centers, with emphasis on areas with high proportions of uninsured children to help implement the SCHIP program
Trend: FY 1997: 8.3 million, FY 1998: 8.7 million.

Goal: (HRSA) Assure access to preventive and primary care for minority individuals.
FY 1999 Target: 65% of population served are minority individuals
Trend: FY 1997: 65% of population served at Health Centers, FY 1998: 64% of population served at health centers.

Goal: (HRSA) Assure access to preventive and primary care for uninsured individuals.
FY 1999 Target: 42%
Trend: FY 1997: 39% of population served at health centers, FY 1998: 41% of population served.

Data for all three goals will be available in May 2000. Percents for the last two goals will include NHSC patients.

On June 4, 1999, the Health Resources and Services Administration announced that two students enrolled in Howard University's Nursing Careers for the Homeless Program are the first to complete their bachelor of science in nursing degree programs. This program was launched in 1993 and since then 96 students were enrolled and are either enrolled in college-level nursing programs or employed in entry-level nursing positions.

Source: HRSA News Brief issued June 4, 1999.

Goal (SAMHSA): Assure services availability/meet targeted needs.
FY 1999 Target: Increase referrals from non-mental health agencies for mental health services by 10%.
FY 1999 Actual: Increased referrals to 80.1%.
Trend: FY 1997: 75%, FY 1998: 79.7%.
Although the target was not achieved, the results are moving in the direction of the target.

FY 1999 Target: Increase percent of client children attending school 75% of the time by 10%. .
FY 1999 Actual: Exceeded the target. 88.9% attending at 12 months.
Trend: FY 1997 Baseline: 70%, FY 1998: 78.8% (12% increase)

Every year, more than 51 million adult Americans experience diagnosable mental disorders. Of them, more than 6.5 million are disabled by severe mental illness, including as many as 4 million children and adolescents.

Community mental health services block grants improve community-based systems of care in order to increase the level of functioning and quality of life for adults with serious mental illnesses and for children with serious disturbances. SAMHSA awarded $288.8 million in community mental health grants in FY 1999. An estimated 151,000 clients were served in systems receiving funds in FY 1999. Performance indicators are still being discussed with the states. A significant problem is the development and use of comparable definitions for the proposed measure. However, for children and their families who receive services at grantee sites under a comprehensive community mental health program, results are demonstrated by measures such as interagency collaboration and client outcomes.

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In response to the severe and ongoing crisis regarding **HIV/AIDS,** HRSA's goal is to provide access to state-of-the-art HIV clinical care for those who have HIV/AIDS and approximately 250,000 HIV-positive people who know their status but are not under care. HRSA awarded $710 million in formula grants to 50 states, the District of Columbia and U.S. territories to improve access to HIV/AIDS primary care, support services, and medications for people living with HIV/ AIDS and their families. This amount includes $461 million earmarked for state ***AIDS Drug Assistance Programs***, ensuring that more than 100,000 low-income individuals living with HIV/AIDS receive life-saving and life-sustaining drug therapies.

Goals for the six Ryan White Care Act programs focus on increasing access to health care services and anti-retroviral therapy and reducing perinatal transmission. The programs have also established goals to serve women and minorities in proportions that exceed their representation in overall AIDS prevalence by a minimum of five percent. Despite the reduction seen in overall AIDS morbidity, the proportion of AIDS cases among women and minorities continues to increase. The benefits provided by new combination drugs have not uniformly reduced the incidence of AIDS. The performance noted below reflects significantly increased efforts across all of the programs to target communities of color.

- *Access to primary medical, dental, mental health, substance abuse, rehabilitative, and home health care:* HIV Emergency Relief Grants: Providing the core response in metropolitan areas hardest hit by the AIDS epidemic. Title I grantees reported 2.79 million visits in FY 1998, moving towards the FY 1999 target of 2.88 million visits. Also in FY 1998 the program exceeded its FY 1999 targets to serve 30 percent women and 64 percent minorities, serving 30.7 and 67.7 percent respectively.

- *HIV Care Grants to States:* In FY 1998 Title II programs reported 1.45 million visits, a 26.2 percent increase over FY 1997 and exceeding the FY 1999 target by approximately 230,000 visits. The program also exceeded its FY 1999 targets for serving minorities and women in FY 1998: 29.4 percent program beneficiaries in FY 1998 were women and 64.1 percent minorities, compared to the FY 1999 targets of 27 percent women and 59 percent minorities served.

- *Access to Primary Care:* In FY 1998 the Title III Early Intervention program exceeded its FY 1999 target of 90,433 clients receiving primary care services. A total of 105,398 persons received primary care services in FY 1998, a 9.3 percent increase compared to FY 1997. In addition, the program provided services to 72,242 minorities in FY 1998, an increase of 14 percent (8,819 minority clients) over FY 1997. The program has exceeded its 1999 target to serve 60,000 minorities for the past two years.

- *Access to Anti-retroviral Therapy:* In FY 1999, an average of 64,500 persons received anti-retroviral therapies each month through the AIDS Drug Assistance Program (ADAP). While an average of 9,500 additional clients were served per month in FY 1999 compared to FY 1998, because of data collection system revisions, the program did not meet its FY 1999 target to serve an average of 78,088 persons per month. The FY 1999 target was set prior to the full implementation of the data collection system for this measure in FY 1999.

Proportion of Women and Minorities served by Emergency Relief Grantees and State Grantees Compared to the Proportion of the U.S. Population with AIDS

Year	Proportion of AIDS patients who are women	Proportion of AIDS patients served by HRSA-funded programs who are women	Proportion of AIDS patients who are minorities	Proportion of AIDS patients served by HRSA-funded programs who are minorities
1996	*15.3%*	*30.3%*	*53.8%*	*64.2%*
1998	*15.8%*	*30.0%*	*55.4%*	*68.0%*

HRSA. Note: Source data contain duplicated client/beneficiary counts.

Of special concern also are health care services for mothers and children of low-income or isolated populations, who otherwise would have limited access to care. In 1999 the safety net for women and children was significantly expanded.

The ***Maternal and Child Health Services (MCH)*** provided $576.2 million in funds to 59 States and jurisdictions in FY 1999 under a matching formula that takes into consideration the percent of the nation's low-income children residing in each. Since MCH is a block grant, the states have discretion in how they spent funds to meet the goals of the program. HRSA will use the aggregated state core measures that states report on, to assess the overall performance in FY 2001. In FY 1999 the program established baselines for the measures and set targets for FY 2001. Selected MCH goals include:

Prenatal health care is important to both mother and child.

- Decrease the infant mortality rate from the FY 1997 rate of 7.1/1000 to 6.9/1000 in FY 2001, and decrease the ratio of the black infant mortality rate to the white infant mortality rate from 2.4 to 1 in FY 1996 to 2.1 to 1 in FY 2001.
- Increase the percent of infants born to women receiving care beginning in the first trimester from 82.5 percent in FY 1997 to 90 percent in FY 2001.
- Increase the percent of children with special health care needs in the State with a medical/health home (as defined and recommended by the American Academy of Pediatrics) from 69 percent in FY 1997 to 80 percent in FY 2001.
- In the Healthy Start Initiative, decrease the percentage of low birth weight babies born to Healthy Start clients from 12.09 percent in FY 1998 to 11.75 percent in FY 2001.

Healthy Start was launched in 1991 to reduce infant mortality in areas with extremely high infant mortality and low birth weight babies. In FYs 1998 and 1999 HRSA focused on replicating the Healthy Start successes. Fifty-five new communities are replicating infant mortality reduction strategies from other communities.

INFANT MORTALITY RATES IN THE UNITED STATES
(DEATHS PER 1,000 LIVE BIRTHS
FOR INFANTS UNDER 1 YEAR OLD)

	1960	1970	1980	1990	1997 *
Infant (All Races)	26.0	20.0	12.6	9.2	7.2**
White	22.9	17.6	10.9	7.6	6.0
Black	44.3	33.3	22.2	18.0	14.2
Hispanic	-	-	-	7.8	6.0

Source: Tables HC 1.1.A & 1.1.B– 1999 Trends in the Well-Being of America's Children & Youth (HHS)

** Preliminary Data*

*** In 1997, the infant mortality rate for American Indians/Alaskan Natives was 8.7 and for Asian/Pacific Islanders was 5.0.*

The ***National Immunization Program*** focuses on several major programmatic areas to achieve its goals, including childhood immunization, adult immunization, and global polio eradication. State and local health agencies play a primary role by using federal grant funds for a wide variety of immunization activities including surveillance. As a result, information shows that immunization coverage levels for adults in the United States have increased for influenza and pneumococcal disease. Progress is still needed among African-Americans and Hispanics.

CDC and HCFA share complementary goals to increase the number of annual influenza and lifetime pneumoccoccal vaccinations among selected populations aged 65 and over. For example, CDC and HCFA shared the FY 1999 goals to increase the annual influenza vaccination rate to near 60 percent. Although final data for this measure is not yet available, CDC data indicates that the rate of vaccination for influenza among persons aged 65 and older increased from 33 percent in FY 1989 to 63 percent in FY 1997.

CDC's REACH grants provide funding for adult immunization activities aimed at eliminating the health disparities. HCFA also stepped up its efforts to increase the number of minorities receiving flu and pneumonia vaccinations this year by mailing nearly 8 million postcards in four languages to remind Medicare beneficiaries to get immunized.

Also, on September 23, 1999, CDC announced that the nation's overall immunization rate for preschool children increased to a record 80 percent in 1998 attaining the highest rate ever recorded. Because childhood vaccination levels in the United States are at an all-time high, disease and death from diphtheria, pertussis, tetanus, measles, mumps, rubella and H.influenza B are at or near record lows. There was only one reported case of diphtheria, 100 reported cases of measles, and no reported cases of wild poliovirus for 1998.

Data show that cases of vaccine-preventable childhood diseases have been reduced by 97 percent from peak levels before the vaccines were available. To ensure that preschool age children continue to be vaccinated against preventable diseases, CDC and HCFA have developed complementary goals to increase the percentage of 2-year old children to receive all recommended childhood vaccinations. CDC's efforts focus on maintaining a 90 percent coverage rate among children 19-35 months for each recommended vaccine. While FY 1999 data will not be available until 2000, data from FY 1997 indicate that CDC met that goal for all but two vaccines. HCFA will continue to develop its goal to increase the percentage of Medicaid enrolled two-year-old children who are fully immunized. The first group of 16 states began developing their methods of measurement and its

Vaccination rate among persons 65 or older

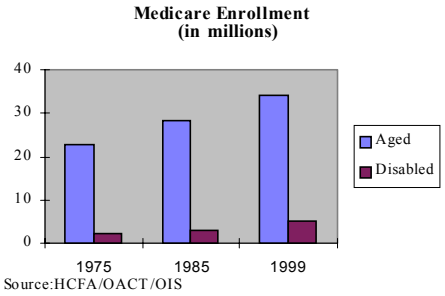
	FY 1995	FY 1997
Influenza	**58%**	**65%**
P. Pneumonia	**34%**	**43%**

CDC National Health Interview Survey: FY 1997 data is preliminary.

Goal: Increase pneumococcal pneumonia and influenza vaccination among persons of 65 years or more.
1999 Targets: Vaccination Rates for Influenza 60%. Pneumococcal pneumonia 54%.
1999 Actuals: Data is not available yet.

For every $1 spent on diphtheria/ tetanus/acellular pertussis vaccination, $27 is saved.

Immunization should begin at an early age.



Source:HCFA/OACT/OIS

Goal: (HCFA) Improve access to care for elderly and disabled Medicare beneficiaries who do not have public or private supplemental insurance.
FY 1999 Target: Work with states to establish an enrollment target for beneficiaries for FY 2000.
FY 1999 Actual: Met.

Medicare and Medicaid provide health services to many Americans.

baselines in FY 1999. They will complete setting their baselines by the end of FY 2000.

All of the national 1996 immunization coverage goals of vaccinating 90 percent of the nation's children by aged two with the most critical doses of routinely recommended vaccines have been achieved and maintained except for Hepatitis B. Coverage for Hepatitis B in 1998 is only three percentage points short of the goal.

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❖ We protected and improved beneficiary health and satisfaction with Medicare and Medicaid.

Medicare and Medicaid together provide health insurance coverage for approximately 75 million elderly, disabled, and economically disadvantaged Americans.

Medicare covers both hospital insurance and insurance for physician and outpatient care, laboratory tests, home health care, durable medical equipment, designated therapy services, and other services not covered by hospital insurance. A new program under Medicare, Medicare+Choice, was created in 1997 to increase health care options for beneficiaries through a greater variety of managed care and fee-for-service plans. Over the last thirty years, Medicare has significantly contributed to life expectancy, to the quality of life, and to protection from poverty for the aged and disabled. In FY 1999, Medicare costs were $184.5 billion.

HCFA and states established a FY 2000 target of a 4 percent increase in enrollments. An additional 211,000 beneficiaries would be enrolled in a dual eligible program (i.e., for both Medicare and Medicaid).

HCFA was among the 30 federal agencies that participated in the independent American Customer Satisfaction Index ratings of customer satisfaction. Recent Medicare beneficiaries were queried for their satisfaction with their HCFA contacts and they gave a rating of 71 percent satisfaction, which exceeds the aggregated federal government rating of 68.6 percent.

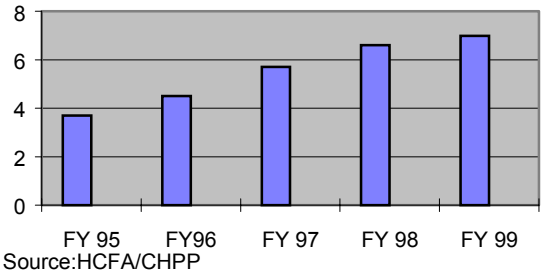
In FY 1999 HCFA also continued to develop an appropriate performance measurement methodology for fee-for-service arrangements and a goal for managed care plans.

In addition, HCFA set a goal and target for sustaining high quality health care options for beneficiaries. Achievement of this goal is dependent upon the marketplace and on receiving applications for managed care operations in rural areas and areas where there are no managed care organizations.

However, in FY 1999 the number of new applications or service areas did not materialize, and 45 managed care organizations terminated their contracts and 54 reduced their service area.

Goal (HCFA): Sustain health plan choices where Medicare beneficiaries have at least one managed care option/choice.
FY 1999 Target: 80% of Medicare beneficiaries have at least one managed care option/choice.
FY 1999 Actual: 76% have at least one managed care option/choice.

Managed Care Enrollment (in millions)

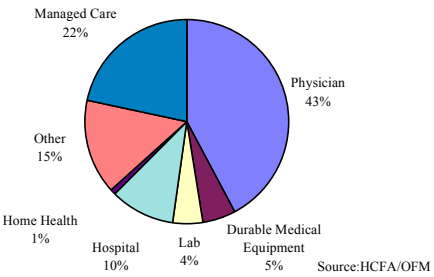


Source:HCFA/CHPP

Goal: (HCFA) Decrease the prevalence of restraints in long-term care facilities.
FY 1999 Target: Decrease use of restraints to 14%.
FY 1999 Actual: Exceeded the target; 11.7%

The prevalence of physical restraints is an accepted indicator of quality of care and is considered a proxy for measuring quality of life for nursing home residents. The use of physical restraints can cause incontinence, pressure sores, loss of mobility and other problems. Many providers and consumers still mistakenly believe that restraints are necessary to prevent residents from injuring themselves.

1999 SMI Medicare Benefit Payments



Source:HCFA/OFM

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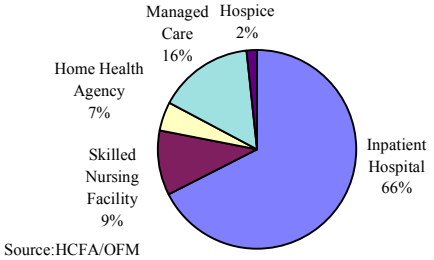
Hospital Insurance, also known as HI or Medicare Part A, is usually provided automatically to people aged 65 and over who have worked long enough to qualify for Social Security benefits and to most disabled people entitled to Social Security, End Stage Renal Disease or Railroad Retirement benefits.

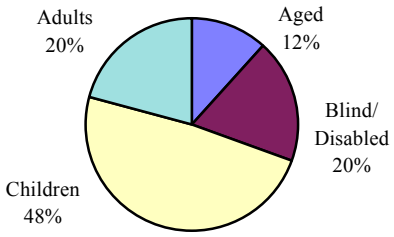
Supplementary Medical Insurance, also known as SMI or Medicare Part B, is available to nearly all people aged 65 and over, End Stage Renal Disease beneficiaries and disabled people entitled to Part A.

1999 HI Medicare Benefit Payments



Source:HCFA/OFM

1999 Medicaid Enrollees

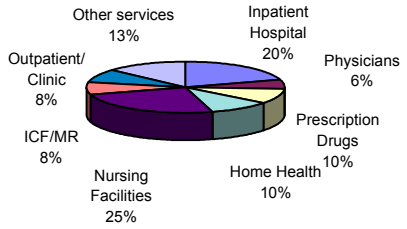


Source:HCFA/OACT

Medicaid is the primary source of health care for medically vulnerable Americans such as poor families, the disabled, and persons with developmental disabilities requiring long term care. Medicaid is administered in partnership with the States. HCFA issues the matching payment grants to states and territories for medical assistance and administrative costs. Medicaid provides health coverage for 41.9 million low-income persons. Medicaid has improved birth outcomes, childhood immunization rates, and access to preventive services, resulting in overall improvements in the health of America's children. Medicaid costs in FY 1999 were $109.0 billion.

Goal: Provide to states linked Medicare and Medicaid data files for dually eligible beneficiaries.
FY 1999 Target: To provide data to 27 states.
FY 1999 Actual: Met the target; data is available to 27 states.

Medicaid Vendor Payments



Source: HCFA/OIS

There were approximately 6 million individuals dually eligible for Medicare and Medicaid. HCFA hopes to foster a service delivery system that is better integrated and more flexible in meeting the needs of dually eligible beneficiaries.

Twenty percent of Medicaid's vendor payments are made to inpatient hospitals.

❖ **We enhanced the fiscal integrity of HCFA programs and ensured the best value health care for beneficiaries.**

HCFA made great strides in 1999 to further define and implement its overall strategy for reducing payment errors in the Medicare and Medicaid programs. HCFA developed a comprehensive program integrity plan based on the key payment safeguard principles for fraud prevention, detection, enforcement, and coordination.

In 1999 HCFA also required more than 250 Medicare managed care risk-based plan (paid on a per-capita rate computed by actuaries) and cost-based plan (paid based on a cost report and audit) ***contractors to report on measures of performance*** on managed care programs. These measures included effectiveness of care, use of services, access to care, and other relevant areas that will provide a better understanding of the performance of the Medicare managed care plans.

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Under the ***Health Care Fraud and Abuse Control Program,*** HCFA, the HHS Inspector General, the Federal Bureau of Investigation, and the Department of Justice, as well as other agencies, including the Administration on Aging, are working together to detect and prevent fraud and abuse.

HHS and the Department of Justice have reported more than $1.6 billion in fines and restitution returned to the Medicare Trust Fund during fiscal years 1997, 1998 and 1999. During these years HHS also excluded more than 8,600 individuals and entities from doing business with Medicare, Medicaid, and other Federal and State health care programs for engaging in fraud or other professional misconduct.

HHS/OIG works with HCFA to develop and implement recommendations to correct systemic vulnerabilities detected during evaluations and audits. These corrective actions often result in health care "funds not expended" (that is, funds put to better use as a result of implemented recommendations for program improvement). During FY 1999 the funds not expended on improper or unnecessary care amounted to approximately $11.8 billion, an increase of $1 billion above FY 1998. Much of this amount reflects savings achieved as a result of legislative amendments brought about by the Balanced Budget Act of 1996 (BBA).

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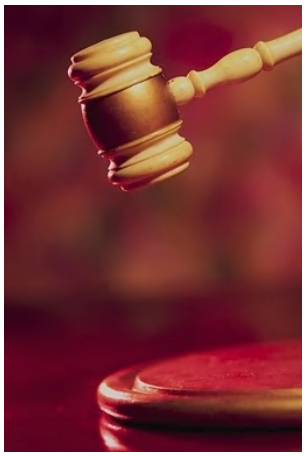

HHS increased convictions in health care cases from 127 convictions in FY 1996 to 303 convictions in FY 1999.

Fraud Hot Line
Call Toll Free:1-800-HHS-TIPS
(1-800-447-8477)
e-mail: HTips@os.dhhs.gov

During FY 1998 and FY 1999, AoA's efforts resulted in training 16,000 retired professionals and other volunteers in the Medicare and Medicaid programs. These volunteers, in turn, educated over 325,000 beneficiaries to identify and protect themselves against fraudulent, wasteful, and abusive health care practices. Where there were questionable charges for medical services, volunteers referred the cases (5,000 in FY 1999) back to health care providers, appropriate Medicare carriers, and ultimately to the HHS Inspector General.

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In FY 1998, HHS announced that for the first time Medicare would hire special consultants who specialize in audits, medical reviews, and internal controls for health programs as an additional effort for the Administration's fight against waste, fraud and abuse. HCFA awarded contracts in FY 1999 to thirteen Program Safeguard Contractors who will work with the ***Medicare Integrity Program*** to end criminal activities by fraudulent health care providers, ensure that Medicare pays only for medically necessary services, and identify honest errors that lead to improper payments.

While we have long known there are billing abuses in the Medicare program, the FY 1996 financial statement audit process gave us our first statistically valid estimated error rate in our Medicare fee-for-service program. Generally, the HHS Inspector General has found that the vast majority of claims are paid correctly based on information submitted on the claim. However, when supporting medical documentation was requested from providers and the services were reviewed the IG found errors in the claims. These errors range from inadvertent mistakes and missing documentation to outright fraud and abuse. The portion attributable to fraud cannot be quantified.

The estimated error rate is quantified in terms of ranges of both dollars and as a percent of program payments. Midpoint estimates are derived from the range figures.

Medicare Fee-for-Service Estimated Error Rates				
	FY 1996	**FY 1997**	**FY 1998**	**FY 1999 Draft**
Midpoint Dollar Estimate	$23.2 billion	$20.3 billion	$12.6 billion	$13.5 billion
Midpoint Percentage Estimate	14%	11%	7.1%	7.97%

As this Accountability Report goes to print, the final results on the FY 1999 error rate are not available. However, draft results indicate that the rate of improvement in the estimated error rate plateaued in FY 1999, as is indicated in the accompanying chart.

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❖ **We strove to improve the health status of American Indians and Alaska Natives.**

In direct partnership with the Tribes, and in recognition of their expanding role in developing and managing the health needs of ***American Indians and Alaska Natives,*** (AI/AN), IHS is working to provide access to basic health services. This includes the assurance of adequate facilities and equipment for the provision of health services and adequate support services to the Tribal health delivery system.

IHS provides access to health care for American Indians and Alaskan Natives.

The IHS, with the Tribes, developed and implemented a policy to ensure tribal consultation and participation in important IHS processes. The policy was in effect at the start of FY 1999. The stakeholders have elected to revisit specific consultation processes and IHS will conduct a baseline satisfaction survey after the policy is updated. IHS also continued to work with Indian Tribes exercising their

Goal: (IHS) Reduce prevalence of diabetes among AI/AN population.
FY 1999 Target: Establish Area age-specific prevalence rates for the AI/AN population.
FY 1999 Actual: Rates are available for IHS Area and sex for 4 age groups from 0 –19 to 65 and over.

self-determination rights through Tribal contracts, Tribal compacts, or continuation of services from the IHS health delivery system.

In FY 1999 under the ***Hospitals and Clinics Program,*** IHS and the Tribes provided essential services for inpatient care, routine and emergency ambulatory care; and support services. The program includes initiatives targeting special health conditions that affect AI/ANs.

In FY 1999 more than $30 million was obligated for 286 grants awarded to IHS facilities, Indian Tribes/Tribal organizations and urban Indian organizations to address the prevention and treatment of diabetes. Diabetes continues to grow in epidemic proportions in Native American communities. In some AI communities, up to half of the adults have diabetes. ***Diabetes*** is 4-8 times more common among American Indians compared to the general U.S. population. Through these grants, diabetes prevention and treatment programs will reach more than 100,000 American Indians/Alaska Natives suffering from diabetes as well as another 30,000 to 50,000 who are at risk.

Goal: (IHS) Improve access to health care by construction of approved new health care facilities.
FY 1999 Target: Conduct construction of facilities scheduled for FY 1999
FY 1999 Actual: Met the target. The completion phase of construction was reached for the Hopi (Polacca), Arizona Health Center. Construction was started on Ft. Defiance, Arizona Hospital and the Parker, Arizona Health Center.

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Once a facility has been completed, IHS has experienced an average increase of approximately 60% more patient visits than in the old facility. To maintain the level of service in the IHS health care delivery system over $182 million was expended for health care facilities. A priority system determines which and when facilities are constructed.

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Many Indian homes lack either a safe water supply or adequate sewage disposal system, or both. There is a demonstrated link between adequate ***sanitation facilities*** and reduced infant mortality, gastroenteritis, and other environmentally related diseases. IHS has undertaken a major effort to provide those facilities. These improvements will also help to reduce the related demands on the IHS health delivery system.

Goal: (IHS) Provide sanitation facilities.
FY 1999 Target: Provide sanitation facilities to 14,130 homes.
FY 1999 Actual: 16,571 homes received sanitation facilities.
Trend: FY 1998: 14,373 homes.

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Under the Older Americans Act, the Administration on Aging provided funding to 225 Indian Tribal organizations representing more than 300 tribes and 2 organizations representing Native Hawaiians. Over 750,000 units of in-home services were provided to Native American older adults in FY 1999 for personal care, homemaker services health aide services, case management, and family support. A total of 600,000 rides to congregate (community) meal sites, doctor appointments, and grocery shopping were also provided. Without the transportation provided, Native Americans residing in isolated areas would not be able to conduct many activities essential to meet their everyday needs.